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Steward

September 30, 2013

David Seltz
Executive Director
Health Policy Commission
Two Boylston Street, 6th floor
Boston, MA 02111

Submitted electronically to HPC-Testimony@state.ma.us

Dear Executive Director Seltz:

Pursuant to your letter dated August 28, 2013 and in accordance with Massachusetts General Laws chapter 6D, § 8, please find included herein Steward Health Care System's responses to the questions outlined in Exhibits B and C. I am legally authorized and empowered to represent Steward Health Care System and provide the enclosed testimony.

Please feel free to call Joseph Maher at 617.419.4708 should you have any questions.

Sincerely,

Ralph de la Torre, MD
Chairman and Chief Executive Officer
Steward Health Care System, LLC

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EXHIBIT B: STEWARD HEALTH CARE RESPONSES TO HEALTH POLICY COMMISSION

Question 1

a) Steward Health Care System (Steward) was created to meet the goals and objectives of health care reform – to provide and achieve the highest quality care in the most cost efficient manner. As a way to achieve this objective, Steward has invested significant resources over the past three years to create an Integrated Community Care Model that improves access to high quality, cost efficient, community-based health care and drives value back to the over 1 million residents we serve.

The Integrated Community Care Model uses publicly available total medical expense (TME) and relative price data – first presented at the Cost Trends Hearings – as a guide to reduce the cost of care for the patients we serve. That data demonstrates that reductions in health care spending can be achieved simply by providing care among high quality, lower cost community settings.

Steward leverages several health insurance product offerings to drive additional value to our patients and employers. Community Choice and Community Care, health insurance products developed in partnership with Tufts Health Plan and Fallon Community Health Plan, respectively, are two limited network products that offer small businesses the benefit of a high quality provider network at up to 30% below the cost of comparable health insurance products. In addition, Steward also offers its employees a health insurance option which covers over 12,000 employees at significantly discounted premiums through a limited network.

Moreover, Steward has invested in population health management programs, which allow Steward to care for high-risk patients and manage their medical care more efficiently and more effectively. Another significant part of our approach has been our investment of more than $130 million in information systems that integrate community-based providers across the continuum of care. Steward's IT system enables our physicians and hospitals to provide real-time coordinated care, while simultaneously mitigating duplication of services and tests. Steward's highly integrated and interoperable IT technology has helped to significantly reduce duplication of diagnostic tests, prevent readmissions, and significantly improve our quality achievements.

b) Areas of opportunity to improve quality and efficiency of care include management of high risk populations and chronic diseases. Steward's patient-focused Population Health Management program includes several initiatives designed to target quality of care, improve the overall health of our members, and lower annual rate of growth of the cost of care. Some of these programs include:

- Clinical Integration Program: Improving quality and prevention through standardization of evidence-based, cost effective clinical protocols across the continuum
- Emergency Room Re-direction: Avoids costly Emergency Department services that are more appropriately delivered by primary care providers (PCPs)
- Complex and Chronic Patient Management: Risk stratification of patient populations to identify and manage high risk / high cost members to prevent avoidable admissions and ED visits
- Readmission Prevention: Acute discharge planning, medication reconciliation, and follow-up visits
- Skilled Nursing Facility (SNF) Patient Management: Focused on reducing the length of stay (LOS) of patients in SNFs while improving outcomes
- Congestive Heart Failure Program: Care Management teams develop care plans for patients with multiple co-morbidities

- Community Health Advocates (CHAs): CHAs currently operate at six Steward hospitals as trusted members of the community that help patients gain access to available health programs and navigate the health care system. Steward's CHAs provide patients with information and assistance to access public insurance programs and aid newly-insured patients in finding a primary care provider, scheduling appointments, and overcoming other barriers to accessing health care, such as transportation or language differences. The CHAs also engage in health promotion with patients, encouraging healthy behaviors, such as good diet and exercise habits.
- Telehealth: Critical care patients receive 24/7 physician and nursing coverage through remote monitoring, resulting in measurable decrease in morbidity, morality and length of stay. Telepsychiatry in two Steward hospital Emergency Departments supports timely evaluation of behavioral health patients. Tele-stroke in five Steward hospital Emergency Departments supports timely evaluation and treatment of stroke patients.

Steward has also invested significant resources and time to develop robust analytics to support community-based care coordination teams and decision-making. These analytics – in conjunction with Steward's IT integration – have reduced unnecessary duplication of services such as imaging across the system. Steward's community-based teams further expand access and create linkages to primary care across our many ethnically diverse communities, an essential strategy for reducing medical costs and unnecessary use of services.

Statewide, one of the largest opportunities to immediately reduce health care costs is to address the significant number of individuals that leave the community and travel into Boston to seek routine care at a higher cost teaching facilities. Data provided at the 2011 Cost Trends hearings revealed that receiving care in Boston is at least 50% more expensive than care provided in the community. Not only does the disparity in commercial rates harm community hospitals and threaten their ability to invest in population health and care coordination initiatives; the migration of volume from the community into Boston forces community providers to make difficult cuts to an inflexible cost structure, eliminating jobs and reducing access to essential services.

Importantly, that same Cost Trends analysis also showed that the quality of care in community hospitals is just as good, and sometimes better than that provided by Boston-based providers. Unfortunately, recent data suggests that the migration toward expensive Boston teaching hospitals has persisted and even grown in the two years since this phenomenon was first publicly reported.

c) The greatest policy or systemic change that would encourage providers to operate more efficiently, lower costs and improve quality concurrently is the immediate implementation of Medicare and Medicaid risk-based, global payment contracts directly with providers. Medicare has begun this process through the Pioneer Accountable Care Organization and Medicare Shared Savings Programs. However Medicaid, unlike the commercial market or the Medicare program, has done little to implement payment reforms or explore direct, risk-based or global arrangements with providers. MassHealth provides government subsidized coverage to over 1.3 million residents at a cost of over $12 billion annually; and it is one of the largest payers in the Commonwealth. While legislation and regulatory policies have forced the commercial market to evolve and lower costs, MassHealth has persisted in maintaining a status quo of fee-for-service payments and rate cuts to providers.

MassHealth should immediately leverage its enormous purchasing power to transform the way in which it pays participating Medicaid providers and lead the transition toward risk-based, global

payment models. MassHealth's continued policy of paying providers under fee-for-service models directly through the FFS/PCC program and indirectly through its MCO health plans has contributed to higher costs and discouraged providers accepting more Medicaid patients.

Risk-based, global payment contracts are the best means of driving value – defined as delivering the highest quality, most cost efficient care. To date, incentives for providers to adopt such payment models and to achieve value are mixed between fee-for-service and risk, creating little incentive for struggling providers to invest in transformative infrastructure, move away from fee for service or to deliver care in less costly, high quality settings. Early adopters of risk-based payment models such as Steward have been forced to operate in an inefficient "mixed mode" of risk and fee-for-service payment structures.

Under a risk payment paradigm, providers are rewarded for care management programs and other quality initiatives -- which often require additional investment – without the need to drive up service volume. However, Medicaid continues to pay under fee-for-service and to reimburse solely based on volume of services without regard to value-based efforts that reduce the volume and intensity of services.

Medicaid can implement risk-based, global payments directly with providers swiftly since a majority of organizations in Massachusetts are already paid under risk-based payments or accountable care like the Medicare Pioneer ACO or Shared Savings. Moreover, these providers care for more than 50% of MassHealth's covered lives. Given this advanced provider market environment, the Massachusetts Medicaid program is positioned to immediately establish direct-to-provider payment contracts directly with a majority of providers and to align Medicaid payment policies with existing Medicare ACO programs, as well as commercial risk-based payment models.

In fact, alignment of all the Commonwealth's major health care programs – MassHealth, the Connector, the Group Insurance Commission – toward direct risk-based contracts with providers will further eliminate the existing misaligned payment incentives and enable integrated provider organizations to not only focus on quality improvement and care management programs, but to lower the overall rate of growth in health care costs.

Finally, MassHealth and other state programs should require all members to select a primary care provider. This will align individuals in a manner appropriate for risk contracting as well as ensure that individuals are receiving the most appropriate care, preventative care, early wellness care, and coordinated care as an additional tool to achieve the most appropriate use of health care services in the most cost efficient settings. Primary care providers should have meaningful input into managing the care of aligned members and should be paid accordingly for accepting the risk and care coordination costs and responsibilities of this effort. Additionally, care management efforts and costs supplied by the providers should be appropriately reimbursed and discounted from health plan premium costs in order to both avoid duplication of costs within premiums and to avoid inadvertently penalizing providers that have successfully become more efficient in managing the cost of care for their patients.

d) In order to pass on lower health care costs to individuals and employers, Steward partnered with two health insurance plans to offer robust, limited network health insurance products. In collaboration with Tufts Health Plan and Fallon Community Health Plan Steward offers Steward Community Care and Steward Community Choice, respectively. These products not only offer a

high quality provider network, but also pass the savings *directly* to consumers and employers in the form of lower premiums. Through the exclusive use of Steward's network of low cost providers, consumers can save as much as 30% of their premium dollars relative to comparable full network HMO products. These Steward insurance products provide an innovative and sustainable solution to the immediate problem of escalating health care costs without sacrificing quality, access to care, or plan benefits.

Finally, Steward is continuing to evolve its relationships with commercial health insurance plans by moving into "percent of premium" contracts. Under the percent of premium model an integrated provider organization such as Steward is placed at risk for a budgeted amount equal to the percent of premium dollar needed to provide medical services and programs for a defined population, while the health plan agrees to the percent of premium dollar needed to administer such contract. Under this model, potentially duplicative administrative costs are reduced or eliminated (IT, care coordination, member engagement, analytics, etc) and population health management programs are clinically integrated into the delivery system, where they are most cost-effective and appropriate. These reforms and payment changes will enable Steward and its partner health plans to directly pass significant premium reductions to employers. A percent of premium model is the most efficient means of focusing medical spending on direct patient medical care, as well as an effective means of reducing costs through care management.

Question 2

Steward has taken significant actions to drive down the annual rate of increase in the total cost of patient care. Over the past year Steward has doubled the number of primary care providers in its network to better provide care across its communities and to enhance our ability to better coordinate care under global payment arrangements. Steward is also partnering with community-based post-acute care providers to improve patient care transitions and to better integrate care across diverse provider platforms. These enhancements, as well as the increase in primary care providers has proven immediate results in better quality, as well as reduced medical spending.

Steward has also invested in two key areas: a robust information technology platform to clinically integrate care across its entire delivery service, as well as risk-based, global contracts to incent and reward its providers to deliver high quality care. An advanced and integrated IT platform enables Steward to coordinate care across a wide spectrum of geographies, services and providers.

Steward has continued to tackle health care spending in innovative ways, including collaborating in the development of two new small group health insurance products designed not only to bend the cost curve and lower premium increases, but to actually reduce premiums. Steward's Community Choice and Community Care products – available through Tufts Health Plan and Fallon Community Health Plan – offer small businesses a high quality health plan with premiums as much as 30% below existing small group products. These offerings provide employer groups in eastern Massachusetts with an affordable alternative to effectively manage the annual growth in premiums. Steward's percent of premium contracts are the next step in reducing medical trend as such arrangements are able to efficiently carve out duplication in programmatic expense and align population health and care management programs with the entity best able to drive positive health outcomes.

Steward is also actively working with the Healthcare Equality and Affordability League (HEAL) to bring attention to the issue of socioeconomic health care disparities in medical spending across communities.

Work by the Attorney General and Division of Health Care Finance and Policy in 2011 revealed a regressive dynamic underlying commercial insurance in Massachusetts whereby lower income communities with low total medical expense (TME) are effectively subsidizing the higher medical spending of individuals in higher income communities. As payers in Massachusetts transition to budget-based models of payment it will be critical to ensure socioeconomic neutrality – that individuals of both low and high income communities are assigned equal TME budgets based on health status.

Question 3

a) As one of the largest providers of inpatient behavioral health services across eastern Massachusetts, Steward is committed to the integration of physical and behavioral health. We believe that high Emergency Department (ED) use is an immediate opportunity for integration. As part of our efforts to better care for behavioral health patients, Steward has established partnerships with several community-based organizations that help us triage behavioral health patients and coordinate their services in the most appropriate site of care.

   More often than not, the ED is the not the most clinically appropriate setting for behavioral health patients to receive care. Additionally, inappropriate use of the ED leads to gaps in care, excessive costs, unreimbursed service expenses, and often disruptive patient care. To address these issues Steward has developed collaborative care committees (CCC) designed to better serve the needs of our behavioral health patients who are frequent users of the ED. These committees work with community partners to address the social determinants of health by connecting them with community-based resources.

   Steward has also implemented a number of strategic initiatives across its system designed to better care for patients with behavioral health complications. For example, at Steward Holy Family Hospital we have worked with the Lawrence police department since 2007 to provide mental health professionals that accompany law enforcement on calls involving a psychiatric concern. Program data has demonstrated its effectiveness at reducing both jail and ED admissions for individuals with behavioral health needs.

   Similarly, for the past two years Steward Good Samaritan Medical Center in Brockton has met monthly with over twenty community partners to connect those patients with a history of inappropriate and excessive ED utilization to more appropriate community-based services, including primary care, behavioral health, and other services that address the social and environmental determinants of health. This targeted intervention has resulted in a 60% reduction in recidivism for frequent utilizers at Good Samaritan Medical Center. Recently, we have expanded this program to include Steward Morton Hospital and Steward Saint Anne's Hospital.

   At St. Elizabeth's, within the context of our medical addiction medicine service we are identifying opportunities for an increased medical/surgical consult service to better engage our medical and surgical staff about the complex medical and psychosocial circumstance that surround patients admitted with co-morbid substance use disorders (SUD). This includes both patients whose primary diagnosis includes an etiologic component of SUD (e.g. sub-acute bacterial endocarditis) and those for whom SUD is secondary but significant (e.g. managing alcohol withdrawal s/p appendectomy). Additionally, the inpatient medical addiction medical unit at St Elizabeth's is exploring the possibility of creating a novel medical student rotation with our affiliate Tufts Medical School which would expand practical knowledge about treatment of addiction across all specialties for medical students.

Finally, St. Elizabeth's has developed a coordinated medical comprehensive health and addiction treatment program for opioid dependent or alcohol dependent pregnant women. This program provides integrated the behavioral health and medical/surgical care through St. Elizabeth's NICU for high-risk women entering the Steward system through any hospital or Steward obstetrics provider.

Unfortunately, under today's payment models, Steward is not reimbursed by virtually any payer for integrating such services. The appropriate financial and quality incentives must exist in order for all providers to build and enhance such programs and more importantly, integrate physical and behavioral health in a sustainable manner that benefits patients.

b) The most immediate challenge to integrating behavioral health is Medicaid's existing payment structure and underpayment of such services. Medicaid is one of the largest payers of behavioral health services in the state, yet continues to pay fee-for-service for such services. MassHealth's also contracts with a managed care health plan which also pays fee-for-service for these services. These two Medicaid payment streams are misaligned and worse, offer no opportunity or incentive for providers to build the appropriate care delivery infrastructure to care for individuals with behavioral health needs across the continuum.

This is exemplified through the boarding issues faced by behavioral health patients and providers. Under the current system, behavioral health care is often uncoordinated and disconnected from medical care of the patient, requiring patients presenting at the ED to wait several hours or days before gaining access to clinically appropriate services (commonly referred to as "ED boarding"). During this time, patients do not receive psychiatric care in the appropriate setting leading to further declines in patient health. Similarly, other patients seeking care in the ED are forced to wait while beds and staff are unnecessarily occupied by an ED "boarder."

Another challenge is the fragmentation of behavioral health services and policies across three state agencies (MassHealth, Department of Mental Health, Department of Public Health), Managed Care health plans under contract with Medicaid, among others; with ultimate accountability for the patient falling in between somewhere. The fragmentation of oversight and payment policies has created a situation where providers not only lose money when they care for such patients, but are also precluded from making meaningful investments to improve behavioral health coordination and care across inpatient and outpatient settings.

Additional challenges include the development of a robust staff to manage administrative aspects of coordination and integration. Unfortunately, relatively few clinicians have both sufficient medical and addiction medicine training to serve in this capacity. Additionally, particular outpatient services such as medication assisted therapy with buprenorphine/naloxone have significant demand but due to training and licensure requirements, few available physicians.

A direct-to-provider payment arrangement, which places the provider at risk for both the infrastructure as well as the delivery of timely and effective care, would align financial and clinical incentives and create clear pathways of accountability and better care outcomes. We believe that a risk-based, ACO payment arrangement will significantly address the fragmentation that results in long ED wait times and allow behavioral health patients to receive seamless coordinated care while virtually eliminating mental health "boarding," as well as affording other individuals the ability to receive necessary emergency care in a more timely manner.

c) Steward strongly believes that many of the issues associated with the lack of coordinated services that individuals with behavioral health issues face pertain to the manner in which providers are paid for the provision of such behavioral health services. As such, any proposal to integrate behavioral health with all medical services (inpatient and outpatient) must comprehensively focus on the re-alignment of the existing financial incentives for the provision of all behavioral and physical health services. Medicaid must lead this movement, as one of the largest payers for behavioral health services in Massachusetts, beginning with improved payments for significant providers or disproportionate providers of behavioral health.

Direct, risk-based payment arrangements, which place providers at full financial risk for the total medical expense and delivery of high quality and timely physical and behavioral health care are the most immediate and effective means of addressing today's fractured system. A direct-to-provider, global risk-based payment would re-align clinical and financial incentives, create clear accountability, and ensure that all medical and behavioral health needs of patients are addressed in a coordinated manner. This payment model would also enable providers to make the necessary investments in their operating structures that improve behavioral health coordination and care outcomes such as information technology, transportation services, and evidenced-based diversionary programs. Integrated behavioral health risk-based payment arrangements will provide increased impetus for providers to develop linkages between and among inpatient services and community-based behavioral health support programs, enhancing the integration of behavioral and physical health needs specific to the populations they serve, not specific to the services that providers may want to offer.

Secondarily, behavioral and physical health integration requires increased training and education of behavioral health issues with medical students. Graduate medical education programs for all specialties should include training regarding the intersection of physical and mental health as well as basic knowledge regarding the ways in which medical care must also address mental health care. Increased incentives for medical students to pursue behavioral health programs will also ensure that in the future more physicians are prepared to view health care in a fully integrated manner which includes behavioral health.

Question 4

a) Steward is committed to delivery system transformation and shares the Commonwealth's vision of more efficient and accountable care through innovative care delivery and payment models. Steward's Integrated Community Care model, originally developed in 2010, provides the infrastructure under which Steward is able to coordinate care in its global and other risk-based payment arrangements. Currently, over 90% of Steward's commercial lives are covered by global contracts or risk-based payment arrangements. Steward is also one of only 23 organizations nationally under a risk-based contract with Medicare though the Pioneer Accountable Care Organization (ACO) program. Under the Medicare Pioneer ACO model, Steward is financially accountable for managing the care, utilization, and overall cost of the health care services (including primary, specialty, ancillary, and hospital care) for the 50,000 Medicare beneficiaries aligned with Steward physicians.

To better provide care under its commercial and Medicare risk-based payment arrangements, Steward has significantly increased its primary care provider capacity over the past two years, more than doubling its number of employed and affiliated PCPs. This expansion enhances Steward's

ability to provide fully integrated care in the communities where our patients reside. Steward has also partnered with a number of community-based, post-acute providers to enhance patient transitions and better integrate care across the entire continuum.

Steward continues to advocate for ACO and risk-based payment models with MassHealth and commercial payers.

b) One of the key factors limiting Steward's ability to adopt broader innovative care delivery and payment models is the misalignment of payment incentives and varying models across payers in Massachusetts, especially in Medicaid. Global payment arrangements vary significantly across commercial payers with respect to quality and performance requirements, adding to administrative cost and making implementation of these arrangements cumbersome. In addition, while the commercial market continues to implement global, risk-based payment contracts with providers, MassHealth has not done the same and continues to pay under siloed programs, all of which pay under fee-for-service and below the cost of care.

   Moreover, misalignment among government payers and oversight agencies including Medicaid, the Commonwealth Connector, the Group Insurance Commission, the Division of Insurance, and the Health Policy Commission exacerbates this problem. These agencies have created redundant, confusing, and occasionally conflicting policies that place significant and unnecessary costs on providers. Alignment – particularly among government funded programs – could serve as an impetus for systemic change toward high quality, integrated models of care and the broader adoption of risk-based alternative payment models.

c) Health plans need to develop and offer health insurance products that help employers and individuals directly realize the financial benefit of their decisions to stay local for their health care and to frequent high-value providers. Steward strongly encourages the state to provide opportunities for fully integrated providers to contract directly with Medicaid, the Connector, and Group Insurance Commission under payment models similar to the Medicare ACO and Shared Savings programs. Collectively, these three agencies cover nearly a third of the state's population. It is essential that the state transition to payment arrangements that appropriately hold providers accountable for improving community health, promoting wellness, lowering cost, and proactively focus on keeping patients healthy; while not unduly burdening providers with contradictory policy requirements or fragmented payment policies. The state, with its sizable purchasing power in health care, is well positioned to lead this transition and to promote innovation through its contracting strategies.

Question 5

a) Labor is a major cost within Steward's overall hospital cost structure, accounting for more than 60% of total hospital expense. Since 2010, salary expenses per staffed bed at Steward hospitals have increased 6.5%, a substantial driver of overall expense increases. When accounting for fringe benefits in addition to salaries (health insurance, etc.) Steward has seen labor costs per bed increase by nearly 10% over the past two years. Given the major role of labor costs in provider cost structures, the position of many providers as large employers within their community, and the implementation of the health care cost growth cap, the next several years will bring additional challenges to managing labor and total costs.

b) Steward does not benchmark its costs against other provider organizations in Massachusetts due to fundamentally different cost structure and requirements. For example, Steward, unlike its non-profit peer hospitals, contributes taxes to the state and the federal government. Also, Steward's unique status as a community-based, integrated provider system, preclude meaningful comparisons with other organizations operating in Massachusetts.

c) Steward manages performance through bi-monthly meetings with leadership staff.

Question 6

Steward strongly supports transparency of cost and quality information. Steward is one of the only providers in Massachusetts to maintain a publicly accessible website that publishes its inpatient quality scores – and its competitors – using publicly reported data (quality.steward.org).

Steward is also a member of the Healthcare Equality and Affordability League (HEAL), a coalition dedicated to transparency of cost and quality information and the reduction of health care payment disparities.

Question 7

Steward commends the Attorney General (AG) and Center for Health Information & Analysis (CHIA) for their work on this year's Cost Trends reports. In recent years, CHIA and the AG's analysis and publications have led to a better understanding of the commercial market in the state. These efforts have uncovered significant disparities within the commercial market, and successfully moved the discussion on health care. However, the commercial market represents only a partial view of health care cost and market issues in the state.

Per Chapter 224, health care cost growth will be benchmarked against total health care expenditures, defined as including both commercial and public spending. Both the AG and CHIA are strongly positioned to extend their analysis to the entire health care marketplace. Given the mandate of Chapter 224 as well as the importance of a holistic understanding of the market dynamics, we strongly recommend that the state conduct an examination of the entire Massachusetts health care market – including Medicare and Medicaid – in future analyses.

Furthermore, as the state considers cost trends, it must pay special attention to the role of patient migration from the community into Boston and its effect on rising premiums for consumers and employers statewide. Finally, state agencies such as MassHealth, the Connector, and Group Insurance Commission must play a larger role in the transformation of Massachusetts health care. These agencies provide coverage for a significant percentage of Massachusetts residents and yet have not taken as much of a meaningful role in the payment reform transition currently taking place in the commercial market. Additionally, agencies with commercial market oversight such as the Division of Insurance, Health Policy Commission and Attorney General must decide whether well-documented disparities in pricing are to remain embedded in new payment models or whether they will play an active role in ensuring a more equitable and efficient health care financing system for all.

<u>Holistically Examine the Massachusetts Health Care Market</u>
While Steward appreciates the value of CHIA's analysis of commercial price variation, premiums and total medical expense (TME) trends, the reported analysis does not capture the whole story behind

price disparities and health care cost growth in Massachusetts. Current work by CHIA has already made apparent that an overwhelming amount of commercial payments go to hospitals with the highest commercial rates in the state, particularly a handful of high cost Boston hospitals. Incorporating data regarding public payer mix, market share, and public payer rates for these hospital organizations drives a more nuanced and refined understanding of the dynamics that have contributed to cost growth and payment disparities.

For example, Steward's own analysis of CHIA data reveals that hospitals with the highest public payer mix receive the lowest commercial rates, debunking the idea that high public payer hospitals are able to "cost shift" or that price disparities are driven by a need to cost shift. Analysis of how commercial, Medicare, and Medicaid rates interact with payer mix reveals that disproportionate share community hospitals are repeatedly disadvantaged relative to high cost teaching hospitals. If the Commonwealth is to reduce the annual increases in health care spending, price disparities must be corrected, but in a manner that accounts for disadvantages such as high public payer mix.

We strongly encourage CHIA to expand its work with respect to the public payer market. The agency is strongly positioned to produce public payer-focused analyses above and beyond what is described above. Including public payer data to the current analysis would not only enhance understanding of medical spending in the state, but also allow for examination of providers in a more holistic and appropriate way. Only with this comprehensive view of the health care market will the Commonwealth be able to fully identify cost drivers, evaluate performance against the cost benchmark, and implement holistic solutions.

<u>Examine the Impact of Patient Migration on Costs and Premiums</u>

Similarly, we strongly recommend that CHIA and the AG examine the impact of provider price disparities and economic inequities on rising premiums. Analysis of discharge data indicates that as payment gaps have grown, more and more commercial volume has been pulled from the communities across eastern and central Massachusetts into high cost Boston hospitals. This forms the crux of Massachusetts' cost spiral: as Boston hospitals pull more commercial volume from the community; health spending rises even faster and community hospitals are further dependent on the low reimbursement of public payers and forced to eliminate services, affiliate with high cost providers, or close; resulting in yet more migration from the community into Boston.

Analysis of publicly available data shows that patient migration to high cost centers is especially prevalent among commercially insured patients for which hospitals receive more favorable reimbursement. Meanwhile, community hospitals in middle income and low income communities –a larger proportion of government-sponsored patients – receive some of the lowest commercial rates in the state. As such, lower income communities and their underpaid community hospitals subsidize the high cost commercial migration to Boston teaching hospitals. We believe that this phenomenon is one of the fundamental problems with our current payment system as well as a driver of rising health care premiums in the state. As such, we urge CHIA to investigate this issue as part of its mission to inform our understanding of the state's cost trends.

<u>Medicaid Must Implement Risk-based, Global Contracts Directly with Providers</u>

Medicaid must immediately implement risk-based, global payment contracts with participating providers. MassHealth provides government subsidized coverage to over 1.3 million residents at a cost of over $12 billion annually. MassHealth is one of the largest payers in the Commonwealth but unlike the commercial market has done little to implement payment reforms that have helped to lower costs

and improve quality. While legislation and regulatory policies have forced the commercial market to evolve and lower costs, MassHealth has stood still and one could argue, hurt the shift to value by preserving the status quo of fee-for-service payments and rate cuts to providers.

EXHIBIT C: STEWARD HEALTH CARE RESPONSES TO OFFICE OF THE ATTORNEY GENERAL

Question 1

Steward does not monitor financial information in the manner requested. When a patient presents in a Steward hospital the care they receive is independent of payer. Revenue data demonstrates that on a per unit basis (discharge or visits) reimbursement from Medicaid and state-sponsored health programs is on average 65% that of commercial, despite a population which often requires much more resources to manage. Steward strongly supports global, risk-based contracting as a means to emphasize a patient-centric, payer-agnostic approach to health care that rewards investments in care management, patient engagement, better care and lower costs.

Question 2

Steward provides care for approximately 300,000 commercial, Medicare, and MassHealth managed care members through value-driven, budget-based risk contracts. Risk-based payment arrangements enable Steward to invest in infrastructure and care coordination programs necessary to offer and sustain high quality, lower cost care.

Steward is currently engaged in risk contracts with commercial payers Blue Cross Blue Shield (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP) as well as Medicare. Steward's total medical expense (TME) trend has outperformed the target budget annually since 2009 for BCBS, HPHC, and THP. Additionally, quality and outcomes scores have improved every year since 2009 across plans; and quality improvements have been clearly measurable in BCBS's Alternative Quality Contract (AQC) program. Steward is also one of only 23 provider organizations nationally participating in Medicare's risk-based Pioneer ACO contract and was one of only 13 organizations to successfully lower its medical cost trend below a shared savings threshold in the initial year of the program.

Steward seeks global and risk-based contracting opportunities because unlike fee-for-service, globally paid arrangements reward the provision of high quality, cost effective care, and allow Steward to make the necessary investments in infrastructure. Pursuing global payment arrangements allows Steward to focus on clinical integration and care improvement initiatives. However, health plans need to continue to evolve and transition their contracting strategy from a focus on budget-based risk contracts to percent of premium contracting.

A percent of premium model is the most efficient means of focusing medical spending on medical services and reducing duplicative administrative spending. Without this evolution, the duplication of care coordination program costs between payers and providers will grow and an increasing percent of "medical spending" will go towards administration of care management. Population health management programs are most effective when embedded within a patient-centered clinically integrated care delivery system. Currently both integrated systems and health plans are investing in these programs, at greater expense to the health care system. The percent of premium model recognizes the need for evolution as providers become more clinically integrated and structured to take on risk. Under this model, health plans set budgets with integrated provider systems based solely on the determined percent of premium dollar which discounts the duplicative administrative costs of the health plan.

Unfortunately, alternative payment arrangements in the commercial market have thus far been confined to managed care (HMO) products. PPO product information reveals that most large health plans have half to two-thirds of their commercial lives in non-risk products. Amongst PCPs who have been with Steward over the past four years, we have observed all-payer annual declines in HMO

membership of 6.4%, 5.8%, and 2.2%. This year-over-year decline in HMO membership negatively impacts the opportunities for both payer and providers under risk-based arrangements as the universe of potential risk membership declines.

Question 3

Steward Health Care Network (SHCN), the contracting arm for Steward Health Care System, analyzes and manages the risk levels of each risk contract with following approach:

1) Prior to entering a risk-based agreement, SHCN Analytics and Negotiation team analyzes historical claims extracts to determine critical factors in managing the specific risk population such as total medical expense levels and trend, membership levels and trends, risk scores, severity trends, retention percentages, service mix, and product benefit specifications. Based on these factors, SHCN projects a level of risk for the given population and negotiates protections to mitigate downside exposure such as percentage share of the deficits, per member per month maximums on deficits, and/or carve-outs of high cost members.

2) In addition to the contract terms, SHCN further addresses financial risk with reinsurance and maintenance of projected reserves needed to cover potential downside risk.

As Steward increases its levels of risk in future contracts, it will be imperative that health plans transfer the commensurate level of premium and reserves to Steward. To date, health plans have shown flexibility on establishing the percentage of risk taken by the provider, but have refused to provide any portion of their reserves to support this risk.

Question 4

Currently, population DxCG Health Status views are provided monthly to Steward at the plan membership level by HPHC and THP, while BCBS sends individual member DxCG scores. For clinical integration and population health management, Steward has the capability of applying customized health status algorithms to all-payer member groupings at the provider, chapter, and network levels, stratified by specific products or clinical conditions and assessed/monitored for change over time.

When provider organizations engage in percent of premium contracting arrangements, there is clear accountability for the provider organization to manage the health of specific populations. To do so effectively, health status assessment models need to be all-payer and capable of being refined with new, non-claims based information, executed on an as needed basis.

Question 5

Reporting on total Steward revenue is limited to the data extracts provided by health plans within the context of a risk arrangement. If data extracts are provided to Steward by the plans, Steward aggregates the information by payer and assesses the total Steward in-network and Steward out-of-network costs. In addition, Steward analyzes the potential for additional retention of care within the community setting and calculates the corresponding savings.

Question 6

Steward has identified labor costs and IT as its key drivers of expense growth in recent years. Labor is a major cost within Steward's overall cost structure, accounting for more than 60% of total expenses. Since 2010, salary expenses per staffed bed at Steward hospitals have increased 6.5%, a substantial driver of overall expense increases. When accounting for fringe benefits in addition to salaries (health insurance, etc.) Steward has seen labor costs per bed increase by nearly 10% over the past two years.

IT is a newer area of spending growth, driven by Steward's transformation into a fully integrated provider system. IT investment is an essential piece of connecting providers across the care continuum, reducing duplicative testing, and improving outcomes.

Question 7

As a part of Steward's Integrated Community Care Model there is a growing focus on health and wellness activities and education in every part of the continuum of care. Among our community based providers we provide education and services that promote healthy lifestyles as well as preventive care such as cancer screening and vaccinations. With our hospital we reinforce the importance of healthy lifestyle to aid in the management of patient's ongoing health. This comes in the form of patient education materials, newsletters given to patients in our facilities and clinics. Additionally, our Employee Health Departments throughout the system consistently reinforce healthy behaviors, sponsor educational activities and provide direct care to Steward employees. Additional programs, such as health coaching and chronic condition management are also provided to our employees in support of their ongoing health care needs.

While health and wellness programs education materials are provided to patients and employees in our hospital, clinics and offices; the most effective way to promote health and wellness is in partnership with patient's primary care provider. At Steward we believe having an established primary care provider is essential to ensuring consistent and effective health outcomes for the patients we serve across the Continuum of care. Currently, we at Steward provide patients with information to access our "Doctor Finder" tool to help establish care with an accountable, primary care provider. Additionally, quality improvement and care coordination programs identified in Exhibit B, question #1(b) are implemented for all patients presenting in Steward hospitals.

Wellness programs are an important aspect of improving quality and long-term outcomes for patients. As with other accountable care initiatives, these programs are most effectively supported under risk-based payment models, as traditional fee-for-service models do not reimburse for extra expenses incurred outside of specific DRGs, nor do they incent providers or health plans to pass on any measurable savings to employers or individuals through lower premiums.